In the first of a new series of *CentrePiece* articles analysing policy innovations by the coalition government, **Zack Cooper** assesses the plans for healthcare reform in the light of recent CEP research.

The NHS White Paper: evolution or revolution?

For those who favour introducing more competition into healthcare, there is quite a bit to like in the NHS White Paper published in July 2010. Health secretary Andrew Lansley's first major policy statement encourages public and private healthcare providers to compete for care; expands patient choice; and places a tremendous premium on publishing transparent information on a number of dimensions of clinical performance (DH, 2010).

These elements of the reforms are crucial for the health service. Ultimately, increasing competition in the NHS is vital to improving quality and efficiency – just as it is in other sectors of the economy. Recent CEP research illustrates that market-based reforms to the NHS in the mid-2000s, which focused on promoting patient choice and hospital competition, saved lives (Cooper et al, 2010a), improved efficiency (Cooper et al, 2010b) and boosted management quality (Bloom et al, 2010).

It is also encouraging that the White Paper calls for allowing flexible pay across the country. Giving hospitals the ability to set wages will allow them to hire the kind of staff they want and need to run their organisations efficiently. Adding pay flexibility should also go a long way towards reducing the staggering variation in mortality across the country. Indeed, widely reported CEP work shows that current pay regulation, which keeps the earnings of medical professionals largely the same wherever they work, has contributed to higher death rates by depressing real wage rates in high cost

areas (Propper and Van Reenen, 2010).

These aspects of the reforms constitute a sensible extension of the successful market-based reforms instituted by the previous Labour government. But the problem is that there are other elements in the reforms that are in tension with this evolution and which break Andrew Lansley's election campaign pledge to avoid sweeping top-down shake-ups of the health service.

In the White Paper, the health secretary proposes a radical shake-up of how care gets commissioned in England. Broadly, he is proposing to shift the commissioning process from primary care trusts (PCTs) to general practitioners (GPs) and in doing so, he is placing an extraordinary amount of power in the hands of clinicians. GPs in England are clearly very capable, but it is not clear that they want to be the principal commissioners of care, that they necessarily have the specific skills to commission services effectively and, perhaps most importantly, that they support the government's broader healthcare reform agenda.

Commissioning care has been a perennial bedbug for the NHS for the last 20 years. Since the purchaser/provider split was introduced in the 1990s, a range of organisations have been tasked with purchasing care on patients' behalf and organising care locally for patients. To date, none of the commissioning bodies have thrived. A damning recent report from the House of Commons highlights concerns that PCTs have been far too passive, have failed to prompt hospitals to improve the quality and efficiency and have not been active enough coordinating highly specialised services for organ transplantation and cancer care (Health Select Committee, 2010). These failures have raised transaction costs in the NHS, allowed hospitals to operate virtually unchecked and hindered efforts to improve care for complex conditions.

There are a number of root causes of these failures. Generally, according to the Health Select Committee, the staff at PCTs are often under-skilled, lack clinical knowledge and have not used data adequately to improve the commissioning process. In part, this is because PCTs have had almost no monetary incentives to improve. Over the last decade, PCTs have seen their budgets grow annually, regardless of their performance.

Under the White Paper proposals, GPs are to be given the ability to commission nearly every aspect of care for NHS patients and they will be collectively responsible for almost the whole of the NHS budget. While there is some reason to believe that this sort of power will increase care in the community (which is vital to reining in NHS spending), the proposals are worrying because having good clinical skills does not necessarily guarantee that GPs will be effective commissioners.

NHS reforms in the mid-2000s helped to increase competition, which saved lives, improved efficiency and boosted management quality

There is some precedent for giving GPs more purchasing power. The previous Conservative government did just that in the 1990s with some positive results. Published evidence examining the GP fundholding policy suggests that it reduced pharmaceutical use, lowered elective referral rates and allowed GPs to make some savings by lowering the demand for clinical services. This kind of check on demand and built-in incentive to provide care locally is badly needed in the NHS right now.

But the GP fundholding programme from the 1990s also had very tangible downsides. In the long term, GP fundholding led to higher managerial and transaction costs because GPs had to spend much more time negotiating with hospitals, and hospitals had to spend more time and money negotiating with them.

In addition, what should also worry David Cameron is that GP fundholding led to a substantial *drop* in measured patient satisfaction during the 1990s. One explanation for this unhappiness is that GPs were spending more time working as managers and less time dealing with patients.

So what are the implications of giving GPs expansive commissioning power more than a decade after GP fundholding was abolished?

For those who favour introducing more competition into healthcare, there are things to like in the NHS White Paper

On the positive side, there is some reason to believe that the transaction costs will be less dramatic than they were 15 years ago. Right now, hospitals cannot alter their reimbursement rates, so the negotiations between GPs and hospitals will be vastly simpler than they were in the 1990s. This time around, in addition to their clinical responsibilities, GPs will spend the bulk of their time purchasing care and planning care pathways, rather than negotiating rates with hospitals.

In addition, the White Paper allows patients to choose who will commission their care. This will create incentives for the GP consortiums to become more efficient if they face a real risk that poor performance will reduce their market share.

Unfortunately, on balance, these reforms seem to be a knee-jerk response to the very real shortcomings of PCTs. The White Paper places unprecedented power in the hands of GPs, with little evidence about whether they are interested in taking on this new role or if they are going to be better equipped to commission than PCTs. To be sure, involving clinicians in the management of the health service is important, but medical knowledge is not wholly akin to the managerial skills that are vital to effective commissioning. We just do not know whether or not GPs will be more or less capable commissioners than PCTs.

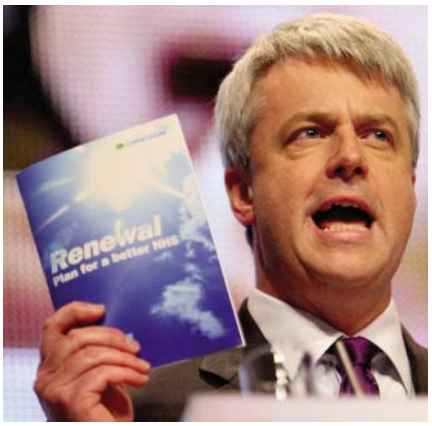
There is plenty of evidence that there are some very entrepreneurial GPs who will thrive at commissioning. But what will happen to the commissioning process for patients registered with GPs who either have no inclination or capacity to purchase services? That problem could prove calamitous.

Another significant problem with giving GPs fundholding power is that it is not clear that they support the government's ambition to increase choice and competition in the NHS. For example, recent work by the King's Fund finds that while over three quarters of patients were extremely keen to have choice, GPs do not regard choice as imperative for patients (Dixon et al, 2010). What is more, GPs are reluctant to offer patients their private sector options for care and, in some cases, they are reluctant to offer patients any choice whatsoever when specialist treatment is required.

It is possible therefore that these reforms will put GPs in a position to throw the government's overall policy agenda off course. In fact, Hamish Meldrum, chairman of the Council of the British Medical Association, has explicitly said that GPs should take over commissioning not to increase competition but so that their monopoly power over the process can blunt the government's push for it.

In sum, there are things to like in the White Paper and it is encouraging that the coalition government is actively promoting choice and competition in the NHS. But with so many unknowns, the wholesale transfer of purchasing power to GPs is too much, too fast.

In the long term, giving GPs purchasing power might very well work, but it needs to be trialled, tested and piloted. This is a general rule for policies across all areas of government. At the moment, when funds are tight, this big a shift of purchasing power to an untested system is an extraordinary gamble given that we know that large-scale shake-ups typically cost substantial amounts of money – something that will be in short supply over the next few years.



The wholesale transfer of purchasing power to GPs is too much, too fast – it threatens to increase spending dramatically, not reduce it

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Further reading

Nick Bloom, Carol Propper, Stephan Seiler and John Van Reenen (2010) 'The Impact of Competition on Management Quality: Evidence from Public Hospitals', CEP Discussion Paper No. 983 (http://cep.lse.ac.uk/pubs/download/dp0983.pdf).

Zack Cooper, Stephen Gibbons, Simon Jones and Alistair McGuire (2010a) 'Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms', LSE Health Working Paper No. 16/2020 (http://www2.lse.ac.uk/LSEHealthAndSocialCare/LSEHealth/pdf/Workingpapers/WP16.pdf).

Zack Cooper, Stephen Gibbons, Simon Jones and Alistair McGuire (2010b) 'Does Hospital Competition Improve Efficiency? An Analysis of the Recent Market-Based Reforms to the English NHS', CEP Discussion Paper No. 988 (http://cep.lse.ac.uk/pubs/download/dp0988.pdf).

Department of Health, DH (2010) *Equity and Excellence: Liberating the NHS*, NHS White Paper (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353).

Anna Dixon, Ruth Robertson, John Appleby, Peter Burge, Nancy Devlin and Helen Magee (2010) *Patient Choice: How Patients Choose and How Providers Respond*, King's Fund (http://www.kingsfund.org.uk/publications/patient_choice.html).

Health Select Committee (March 2010) *Health Committee Fourth Report* – Commissioning, House of Commons.

Carol Propper and John Van Reenen (2010) 'Can Pay Regulation Kill? Panel Data Evidence on the Effect of Labour Markets on Hospital Performance', *Journal of Political Economy* (earlier version available as CEP Discussion Paper No. 843 (http://cep.lse.ac.uk/pubs/download/dp0843.pdf).